POLICY AND COMMUNICATIONS BULLETIN
THE CLINICAL CENTER

Medical Administrative Series

M86-8 (rev.) 9 September 1997

MANUAL TRANSMITTAL SHEET

SUBJECT: Contingency Plan for Handling a Shortage of Intensive Care Beds in a Clinical Center Intensive Care Unit

1. Explanation of Material Transmitted: This issuance sets forth Clinical Center policy on how a shortage of intensive care beds in any of its Intensive Care Units (ICUs), viz., the 2J-Surgical ICU or 10D-MICU, is to be handled. The policy was reviewed by the Medical Executive Committee on 9 September 1997 and approved with changes.

2. Material Superseded: MAS No. 86-8, dated 3 December 1986

3. Filing Instructions: "Other" Section

   Remove: No. 86-8, dated 3 December 1986

   Insert: No. M86-8 (rev.), dated 9 September 1997

DISTRIBUTION

Physicians, Dentists and Other Practitioners Participating in Patient Care

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M86-8 (rev.) 9 September 1997

SUBJECT: Contingency Plan for Handling a Shortage of Intensive Care Beds in a Clinical Center Intensive Care Unit

PURPOSE

This policy issuance sets forth a contingency plan for handling a shortage of intensive care beds in any of the Clinical Center's Intensive Care Units (ICUs), viz., the 2J-Surgical ICU and 10D-MICU. The plan was initially approved by the Surgical-Administrative Committee on November 19, 1986, and by the Medical Board on December 2, 1986.

POLICY

1. When no bed is available in a given ICU for a patient needing admission to that ICU, and when, in the opinion of the attending physician or designee, no patient presently occupying a bed in that ICU can be moved to a general patient care unit, physicians in that ICU may seek to locate a bed in the other ICU.

2. If a bed is available in an alternate unit, the patient may be admitted to that unit only with the consent of its admitting physician. The physician requesting the bed will be responsible for contacting the admitting physician. Responsibility for medical care of the patient will rest with the physicians of the unit to which the patient would ordinarily have been admitted. For example, if 10-D were full, and a medical patient were admitted to 2-J, the 10-D medical staff

would be responsible for the patient's care, unless some other mutually agreeable arrangement was made.

3. Physicians of the two ICUs agree to allow other units' physicians to admit and care for a critically ill patient in their unit, when shortages as outlined here arise, unless there are medical contraindications. Aside from those exceptions, one ICU group will be allowed to "borrow" an ICU bed in another unit with the understanding that this represents a temporary admission, and that the patient will promptly be returned to the appropriate ICU as soon as a bed is available.

4. Because a bed shortage may occur at any hour of the day or night, each ICU Chief will delegate to each ICU attending physician the responsibility for deciding which patient, if any, may be moved from that ICU to make room for a case more urgently in need of specialized care. Each attending physician or designee on each ICU should make this assessment with the head nurse or charge nurse at the end of each shift.

5. When the assessment is made as to which patient in the ICU will be moved in the event of the need to make room for a more acutely ill patient, that information will be communicated to the displaced patient's unit of origin so that both medical and nursing needs may be anticipated. It is the responsibility of that unit's Head Nurse or Nursing Service Chief to adjust nurse staffing to accommodate the patient. This includes assessing the clinical needs of the patient and the competencies of available nurses. Unit staffing needs will be assisted by other unit and service resources in house when there is an urgent need.

   Staffing needs will be aided by implementation of additional flexible scheduling options and on-call status pay for nurses. (Implementation pending.)